

Complete Summary

GUIDELINE TITLE

Suicidality and violence in patients with HIV/AIDS.

BIBLIOGRAPHIC SOURCE(S)

New York State Department of Health. Suicidality and violence in patients with HIV/AIDS. New York (NY): New York State Department of Health; 2007. 11 p. [12 references]

GUIDELINE STATUS

This is the current release of the guideline.

This guideline updates a previous version: Suicidality in patients with HIV/AIDS. In: Mental health care for people with HIV infection: HIV clinical guidelines for the primary care practitioner. New York (NY): New York State Department of Health; 2001 Mar. p. 53-8.

COMPLETE SUMMARY CONTENT

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 METHODOLOGY - including Rating Scheme and Cost Analysis
 RECOMMENDATIONS
 EVIDENCE SUPPORTING THE RECOMMENDATIONS
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 INSTITUTE OF MEDICINE (IOM) NATIONAL HEALTHCARE QUALITY REPORT
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SCOPE

DISEASE/CONDITION(S)

- Human immunodeficiency virus infection/acquired immune deficiency syndrome (HIV/AIDS)
- Suicidal behavior, defined as suicidal ideation; suicide attempts; deliberate self harm, with or without suicidal intent; or completed suicide
- Violence, defined as the threatened or actual use of physical force against another person with the intent to cause harm

GUIDELINE CATEGORY

Management
Risk Assessment

CLINICAL SPECIALTY

Allergy and Immunology
Family Practice
Infectious Diseases
Internal Medicine
Psychiatry

INTENDED USERS

Advanced Practice Nurses
Health Care Providers
Physician Assistants
Physicians
Public Health Departments

GUIDELINE OBJECTIVE(S)

To provide guidelines for management of suicidality and violence in patients with human immunodeficiency virus/acquired immune deficiency syndrome (HIV/AIDS) in primary care settings

TARGET POPULATION

Patients with human immunodeficiency virus/acquired immune deficiency syndrome (HIV/AIDS)

INTERVENTIONS AND PRACTICES CONSIDERED

1. Assessment for depression
2. Baseline and annual assessments for suicidal and violent behavior
3. Assessment for specific risk factors for patients who have expressed thoughts of suicide or violence
4. Involving the patient's family and friends and organizing support by providing access to and information about community-based services
5. Escorting patient to emergency department or calling 911 for emergency evaluation when risk factors indicate imminent danger
6. Referral for complete mental health examination
7. Discussion with the patient about his or her suicidal or violent thoughts and development of plan to modify risk factors

MAJOR OUTCOMES CONSIDERED

Prevalence and risk of suicidality and violent behavior in human immunodeficiency virus (HIV)-infected patients

METHODOLOGY

METHODS USED TO COLLECT/SELECT EVIDENCE

Hand-searches of Published Literature (Primary Sources)
Hand-searches of Published Literature (Secondary Sources)
Searches of Electronic Databases

DESCRIPTION OF METHODS USED TO COLLECT/SELECT THE EVIDENCE

Not stated

NUMBER OF SOURCE DOCUMENTS

Not stated

METHODS USED TO ASSESS THE QUALITY AND STRENGTH OF THE EVIDENCE

Expert Consensus (Committee)

RATING SCHEME FOR THE STRENGTH OF THE EVIDENCE

Not applicable

METHODS USED TO ANALYZE THE EVIDENCE

Review

DESCRIPTION OF THE METHODS USED TO ANALYZE THE EVIDENCE

Not stated

METHODS USED TO FORMULATE THE RECOMMENDATIONS

Expert Consensus

DESCRIPTION OF METHODS USED TO FORMULATE THE RECOMMENDATIONS

The Human Immunodeficiency Virus (HIV) Guidelines Program works directly with committees composed of HIV Specialists to develop clinical practice guidelines. These specialists represent different disciplines associated with HIV care, including infectious diseases, family medicine, obstetrics and gynecology, among others. Generally, committees meet in person 3 to 4 times per year, and otherwise conduct business through monthly conference calls.

Committees meet to determine priorities of content, review literature, and weigh evidence for a given topic. These discussions are followed by careful deliberation

to craft recommendations that can guide HIV primary care practitioners in the delivery of HIV care. Decision making occurs by consensus. When sufficient evidence is unavailable to support a specific recommendation that addresses an important component of HIV care, the group relies on their collective best practice experience to develop the final statement. The text is then drafted by one member, reviewed and modified by the committee, edited by medical writers, and then submitted for peer review.

RATING SCHEME FOR THE STRENGTH OF THE RECOMMENDATIONS

Not applicable

COST ANALYSIS

A formal cost analysis was not performed and published cost analyses were not reviewed.

METHOD OF GUIDELINE VALIDATION

Peer Review

DESCRIPTION OF METHOD OF GUIDELINE VALIDATION

Not stated

RECOMMENDATIONS

MAJOR RECOMMENDATIONS

Introduction

Clinicians should clearly instruct medical support staff about how to manage emergencies involving patients with suicidal or violent behavior, such as contacting emergency services or isolating the patient from other patients.

Clinicians should obtain an emergency evaluation if they determine that a patient is at imminent risk of harm to self or others. Patients who are not at immediate risk should be referred to outpatient mental health services when the mental health treatment by the primary care clinician is unsuccessful.

Clinicians should assess HIV-infected patients for depression to ensure early detection and treatment of patients who may be at increased risk of suicide due to depressive symptoms.

Key Point:

A significant percentage of patients who commit suicide will have seen their primary care clinician in the month before their suicide. This underscores the importance of routine mental health screening in the primary care setting, which

can help identify patients who are at risk for suicide and enable them to receive treatment for the underlying cause of their suicidal behavior.

Prevalence and Risk of Suicide and Violence

Key Point:

The combination of mental health and substance use disorders places people at the greatest risk for violence

Assessment of Suicidal and Violent Behavior

Detection of Suicidal and Violent Behavior

Clinicians should assess for suicidal and violent behavior at baseline and at least annually as part of the mental health assessment. (See Figure 1 in the original guideline document for the algorithm: "Assessing and Managing Suicidal or Violent Patients.")

Estimation of Risk for Suicide or Violence

Clinicians should assess patients who have expressed thoughts of suicide or violence for specific risk factors that indicate suicidal or violent intent and for impaired impulse control (see Tables 1 and 2 below).

Table 1. Risk Factors for Suicide and Violence		
Category	Risk Factors	
	Suicide	Violence
Demographic	<ul style="list-style-type: none"> • White • Male (males more often complete; females more often attempt*) • Older age (>45 years) • Divorced, never married, or widowed • Unemployed 	<ul style="list-style-type: none"> • Young • Male • Limited education • Unemployed
Historical	<ul style="list-style-type: none"> • Previous suicide attempts, especially with serious intent, lethal means, or disappointment about survival • Family history of suicide • Victim of physical or sexual abuse 	<ul style="list-style-type: none"> • Previous history of violence to self or others, especially with high degree of lethality • History of animal torture • Past antisocial or criminal behavior • Violence within family of origin • Victim of physical or sexual abuse
Psychiatric	<ul style="list-style-type: none"> • Diagnosis: Affective 	<ul style="list-style-type: none"> • Diagnosis: Substance-

Table 1. Risk Factors for Suicide and Violence		
Category	Risk Factors	
	Suicide	Violence
	<p>disorder, alcoholism, panic disorder, psychotic disorders, severe personality disorder (especially antisocial and borderline)</p> <ul style="list-style-type: none"> • Symptoms: Suicidal or homicidal ideation; depression, especially with hopelessness, helplessness, anhedonia, delusions, agitation; mixed mania and depression; psychotic symptoms, including command hallucinations and persecutory delusions • Current use of alcohol or other drugs • Recent hospitalization for mental health disorder 	<p>related disorders, especially alcoholism; antisocial personality disorder, conduct disorder; intermittent explosive disorder, pathological alcohol intoxication, psychoses (e.g., paranoid)</p> <ul style="list-style-type: none"> • Symptoms: Physical agitation; intent to kill or take revenge; identification of specific victim(s); psychotic symptoms, especially persecutory delusions and command hallucinations to commit violence • Current use of alcohol or other drugs
Environmental	<ul style="list-style-type: none"> • Recent loss such as that of a spouse or job • Access to guns or other lethal weapons • Social acceptance of suicide • Patient's perception of a lack of social support,** or actual lack of social support 	<ul style="list-style-type: none"> • Access to guns or other lethal weapons • Living under circumstances of violence • Membership in violent group • Patient's perception of a lack of social support,** or actual lack of social support
Medical	<ul style="list-style-type: none"> • Severe medical illness: Presence of HIV-related physical symptoms; poor adjustment to HIV disease; failed medical treatment or first hospitalization for medical illness; loss of function or intractable or chronic pain from medical illness • Delirium or confusion caused by central nervous system dysfunction 	<ul style="list-style-type: none"> • Severe medical illness: Presence of HIV-related physical symptoms; poor adjustment to HIV disease; failed medical treatment or first hospitalization for medical illness; loss of function or intractable or chronic pain from medical illness • Delirium or confusion caused by central nervous system dysfunction • Disinhibition caused by traumatic brain injuries and other central nervous system dysfunctions • Toxic states related to

Table 1. Risk Factors for Suicide and Violence		
Category	Risk Factors	
	Suicide	Violence
		metabolic disorders, such as hyperthyroidism
Behavioral	<ul style="list-style-type: none"> • Antisocial acts • Poor impulse control, risk taking, and aggressiveness • Preparing for death (e.g., making a will, giving away possessions, stockpiling lethal medication) • Well-developed, detailed suicide plan • Statements of intent to inflict harm on self or others 	<ul style="list-style-type: none"> • Antisocial acts • Agitation, anger • Poor impulse control; risk-taking or reckless behavior • Statements of intent to inflict harm

Adapted, with permission, from Cournos F, Cabaniss D. Clinical evaluation and treatment planning: A Multimodal Approach. In: Psychiatry, Second Edition. (Tasman A, Kay J, Lieberman J, eds). Chichester, England: John Wiley and Sons Ltd.; 2003.

* This distinction between male and female suicidal behavior may not apply to gay and lesbian youth, who may be at increased risk for suicide attempts associated with experience of harassment, homophobia, gender nonconformity, and disclosure of sexual identity.

** In some cases, patients who are depressed may have family or friends who are supportive, but the patients do not perceive them as being supportive.

Key Point:

People who lack adequate impulse control may represent a serious risk despite stated wishes not to harm themselves or others.

Table 2. Factors That May Increase Impulsivity
<ul style="list-style-type: none"> • Patients do not feel able to control their feelings, impulses, behaviors • Patients are currently using or withdrawing from alcohol or other substances • Patients are acutely psychotic and experiencing command auditory hallucinations and persecutory delusions • Patients have had a decline in cognitive function (gradual or accelerated) • Patients are agitated or manic

Management and Referral of Suicidal and Violent Patients

Clinicians should maintain an up-to-date list of easily accessible mental health referral resources for patients who require either immediate mental health assessment or for whom assessment is less urgent.

Clinicians should attempt to involve people whom the patient perceives as supportive, such as friends and family, in treatment planning and management.

Key Point:

Social support is fundamental to effective management of suicidal and potentially violent patients and can enable patients to accept help. Sources of support may include involvement of family, friends, or community-based services and the clinician's interest in understanding reasons for patients' wishes to harm themselves or others.

Imminent Suicidal or Violent Potential

The clinician, or a member of the health care team, should escort a patient to the emergency department or call 911 when the patient expresses suicidal or violent thoughts accompanied by risk factors that indicate imminent danger. (See Figure 1 in the original guideline document for the algorithm: "Assessing and Managing Suicidal or Violent Patients.")

Non-imminent Suicidal or Violent Potential with Accompanying Risk Factors

Clinicians should refer patients who express suicidal or violent thoughts, but who are not at imminent risk, for a complete mental health evaluation when the mental health treatment by the primary care clinician is unsuccessful. (See Figure 1 in the original guideline document for the algorithm: "Assessing and Managing Suicidal or Violent Patients.")

Clinicians should discuss with patients the reasons why they think about suicide or violence and should develop a plan to modify risk factors.

Key Point:

Patients with chronic suicidal and/or violent ideation often require long-term psychiatric treatment.

Chronic Suicidal or Violent Ideation

Clinicians should refer patients who express chronic wishes to harm self or others for a comprehensive outpatient mental health evaluation and then maintain ongoing communication with the mental health provider(s) involved in the patients' mental health care.

Table 3. Management Strategies for Chronic Suicidal and/or Violent Ideation		
Type of Chronic Ideation	Description	Management Strategy
Chronic suicidal and/or violent	May be a feature of personality disorders, such as borderline or antisocial personality disorder, or a feature of chronic mental health	These patients usually require close coordination of treatment and communication between the primary care clinician and the

Table 3. Management Strategies for Chronic Suicidal and/or Violent Ideation

Type of Chronic Ideation	Description	Management Strategy
ideation resulting from mental health disorders	disorder, such as schizophrenia.	mental health provider. Inpatient psychiatric hospitalization may be necessary during periods of acute crises.
Chronic suicidal ideation as a coping strategy	May be a coping strategy for patients with chronic medical illness. For these patients, thinking about suicide may be an unconscious attempt to regain a sense of control over their lives. Patients may say or think, Well, if things get too overwhelming, I can always kill myself. Such thoughts may lend some sense of control to patients by providing a future option that never has to be acted on. When no other risk factors are present, most patients who express this type of suicidal thinking do not act on it.	During acute crises or when other risk factors are present, these patients may be at more significant risk for suicide and require mental health assessment or inpatient hospitalization.
Chronic suicidal ideation among patients with desire for hastened death	Some patients, usually those with more advanced disease, may request that their clinicians assist them in either suicide or hastened death. Additionally, some patients may wish to hasten their own deaths by refusing treatment. These patients may be suffering from a reversible mental health disorder, most notably depression, which could contribute to their wish to die.	A mental health assessment should be performed to address any correctable problems, such as depression and poorly controlled anxiety, pain, or delirium.
Chronic suicidal ideation among self-injurious patients	Patients may also present with chronic and repetitive self-injurious behaviors, such as cutting, that may or may not be associated with suicidal intent. These behaviors are more likely to occur in patients with borderline and antisocial personality disorders. In these patients, self-inflicted injury may be an expression of anger or frustration and serves to relieve internal tension. They may feel better after injuring themselves.	These patients may benefit from ongoing specialized outpatient mental health treatment. They may also require brief mental health inpatient hospitalizations during crisis periods, when suicidal potential is heightened. See the National Guideline Clearinghouse (NGC) summary of the New York State Department of Health guideline Personality Disorders in Patients With HIV/AIDS .

CLINICAL ALGORITHM(S)

An algorithm is provided in the original guideline document for "Assessing and Managing Suicidal or Violent Patients."

EVIDENCE SUPPORTING THE RECOMMENDATIONS

TYPE OF EVIDENCE SUPPORTING THE RECOMMENDATIONS

The type of supporting evidence is not specifically stated for each recommendation.

BENEFITS/HARMS OF IMPLEMENTING THE GUIDELINE RECOMMENDATIONS

POTENTIAL BENEFITS

- Appropriate management of suicidality and violence in patients with human immunodeficiency virus/acquired immune deficiency syndrome (HIV/AIDS)
- Although only a small number of human immunodeficiency virus (HIV)-infected patients attempt or commit suicide or violence, routine mental health assessment and procedures in the clinic setting for responding to mental health emergencies can ensure that the potential for such behavior is identified and appropriately addressed.

POTENTIAL HARMS

Not stated

IMPLEMENTATION OF THE GUIDELINE

DESCRIPTION OF IMPLEMENTATION STRATEGY

Following the development and dissemination of guidelines, the next crucial steps are adoption and implementation. Once practitioners become familiar with the content of guidelines, they can then consider how to change the ways in which they take care of their patients. This may involve changing systems that are part of the office or clinic in which they practice. Changes may be implemented rapidly, especially when clear outcomes have been demonstrated to result from the new practice such as prescribing new medication regimens. In other cases, such as diagnostic screening, or oral health delivery, however, barriers emerge which prevent effective implementation. Strategies to promote implementation, such as through quality of care monitoring or dissemination of best practices, are listed and illustrated in the companion document to the original guideline (*HIV clinical practice guidelines*, New York State Department of Health; 2003), which portrays New York's HIV Guidelines Program. The general implementation strategy is outlined below.

- Statement of purpose and goal to encourage adoption and implementation of guidelines into clinical practice by target audience.
- Define target audience (providers, consumers, support service providers).

- Are there groups within this audience that need to be identified and approached with different strategies (e.g., HIV Specialists, family practitioners, minority providers, professional groups, rural-based providers)?
- Define implementation methods.
 - What are the best methods to reach these specific groups (e.g., performance measurement consumer materials, media, conferences)?
- Determine appropriate implementation processes.
 - What steps need to be taken to make these activities happen?
 - What necessary processes are internal to the organization (e.g., coordination with colleagues, monitoring of activities)?
 - What necessary processes are external to the organization (e.g., meetings with external groups, conferences)?
 - Are there opinion leaders that can be identified from the target audience that can champion the topic and influence opinion?
- Monitor progress.
 - What is the flow of activities associated with the implementation process and which can be tracked to monitor the process?
- Evaluate.
 - Did the processes and strategies work?
 - Were the guidelines implemented?
 - What could be improved in future endeavors?

IMPLEMENTATION TOOLS

Clinical Algorithm
 Personal Digital Assistant (PDA) Downloads
 Resources

For information about [availability](#), see the "Availability of Companion Documents" and "Patient Resources" fields below.

INSTITUTE OF MEDICINE (IOM) NATIONAL HEALTHCARE QUALITY REPORT CATEGORIES

IOM CARE NEED

Getting Better
 Living with Illness

IOM DOMAIN

Effectiveness
 Patient-centeredness

IDENTIFYING INFORMATION AND AVAILABILITY

BIBLIOGRAPHIC SOURCE(S)

New York State Department of Health. Suicidality and violence in patients with HIV/AIDS. New York (NY): New York State Department of Health; 2007. 11 p. [12 references]

ADAPTATION

Not applicable: The guideline was not adapted from another source.

DATE RELEASED

2001 Mar (revised 2007 Jan)

GUIDELINE DEVELOPER(S)

New York State Department of Health - State/Local Government Agency [U.S.]

SOURCE(S) OF FUNDING

New York State Department of Health

GUIDELINE COMMITTEE

Mental Health Guidelines Committee

COMPOSITION OF GROUP THAT AUTHORED THE GUIDELINE

Not stated

FINANCIAL DISCLOSURES/CONFLICTS OF INTEREST

Not stated

GUIDELINE STATUS

This is the current release of the guideline.

This guideline updates a previous version: Suicidality in patients with HIV/AIDS. In: Mental health care for people with HIV infection: HIV clinical guidelines for the primary care practitioner. New York (NY): New York State Department of Health; 2001 Mar. p. 53-8.

GUIDELINE AVAILABILITY

Electronic copies: Available from the [New York State Department of Health AIDS Institute Web site](#).

Print copies: Available from Office of the Medical Director, AIDS Institute, New York State Department of Health, 5 Penn Plaza, New York, NY 10001; Telephone: (212) 268-6108

AVAILABILITY OF COMPANION DOCUMENTS

The following are available:

- Appendix I: interactions between HIV-related medications and psychotropic medications: indications and contraindications. New York (NY): New York State Department of Health; 2001 Dec. Electronic copies: Available from the [New York State Department of Health AIDS Institute Web site](#).
- Appendix II: HIV-related causes of psychiatric symptoms: differential diagnosis. New York (NY): New York State Department of Health; 2001 Dec. Electronic copies: Available from the [New York State Department of Health AIDS Institute Web site](#).
- Appendix III: rating scales. New York (NY): New York State Department of Health; 2001 Dec. Electronic copies: Available from the [New York State Department of Health AIDS Institute Web site](#).
- Appendix IV: mental health care resources in New York State. New York (NY): New York State Department of Health; 2001 Dec. Electronic copies: Available from the [New York State Department of Health AIDS Institute Web site](#).
- Appendix V: syringe access resources in New York State. New York (NY): New York State Department of Health; 2001 Dec. Electronic copies: Available from the [New York State Department of Health AIDS Institute Web site](#).
- Appendix VI: permanency planning and transitional services. New York (NY): New York State Department of Health; 2001 Dec. Electronic copies: Available from the [New York State Department of Health AIDS Institute Web site](#).

Print copies: Available from Office of the Medical Director, AIDS Institute, New York State Department of Health, 5 Penn Plaza, New York, NY 10001; Telephone: (212) 268-6108

This guideline is available as a Personal Digital Assistant (PDA) download from the [New York State Department of Health AIDS Institute Web site](#).

PATIENT RESOURCES

None available

NGC STATUS

This NGC summary was completed by ECRI on May 5, 2005. This NGC summary was updated by ECRI on February 22, 2007.

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